CARDIOVASCULAR MEDICINE, PLLC

Bring all current medications to your appointment including vitamins, herbal medications and any over-the-counter medications

**Patient Medical History**

*Please complete this form before your appointment*

Date of Appointment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Pharmacy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADVANCED DIRECTIVES:** Durable Power of Attorney (Will): Yes No

Healthcare Proxy (Living Will): Yes No

**ALLERGIES:**

|  |  |
| --- | --- |
| Drugs and Reaction: | |
| Seafood or Shellfish Yes No | Iodine/X-Ray Contrast Yes No |
| Latex Yes No | |

**SOCIAL HISTORY:**

Marital Status: Married Single Divorced Widowed Other

Children: Yes, Daughters (#) \_\_\_\_\_\_\_\_\_ Sons (#) \_\_\_\_\_\_\_\_ No

Employed: Yes, Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No Retired Disabled

Diet Regular Special \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exercise Sedentary Moderate Vigorous

Tobacco Use Never Yes, please continue filling out next section:

* Tobacco Products Used Cigarettes Cigars Pipe Chewing Vaping

How many per day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of Years Used \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age Started \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age Stopped\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Year Quit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol Consumption Yes No If yes, type and amount \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Drug Use Yes No

Caffeine Consumption Yes No If yes, type and amount \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY CARDIAC HISTORY:**  *Please include cardiac/vascular history; heart attack, congenital heart problems, sudden death, arrhythmia, congestive heart failure, stroke, stents in legs or heart, pacemaker etc.*

**Family history of Coronary Disease before 60 years old? Yes No Adopted? Yes**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Member** |  | **Living** | **Deceased** | **Age** | **History** | **Cause of Death** |
| Father |  |  |  |  |  |  |
| Mother |  |  |  |  |  |  |
| Brother (s) |  |  |  |  |  |  |
| Sister (s) |  |  |  |  |  |  |

**PAST MEDICAL HISTORY:**

**Mark if you have ever had or currently have the following and the year:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Diabetes |  |  | High Cholesterol |  |  |
| Blood Clots |  |  | Hypertension |  |  |
| Sleep Disorder |  |  | Heart Attack |  |  |
| Tuberculosis |  |  | Stroke/TIA’s |  |  |
| Lung Disease |  |  | Rheumatic Fever |  |  |
| Asthma |  |  | Thyroid Disease |  |  |
| Heart Murmurs |  |  | Peripheral Vascular Disease |  |  |
| Kidney Disease |  |  | Blood Transfusions |  |  |
| Cancer |  |  | Hepatitis |  |  |
| Other: | | | | | |

**√ Year √ Year SURGICAL HISTORY:**

|  |  |
| --- | --- |
| **Surgeries** | **Year** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**CARDIAC HISTORY:**

**Please list previous cardiac procedures (Stress test, Echocardiogram, Heart Catheterization, etc.)**

1).**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Year:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

2).\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Year:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3).\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Year:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4).\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Year:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5).\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Year:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REVIEW OF SYSTEMS:**

***PLEASE CHECK ONLY WHAT IS A CURRENT OR ONGOING PROBLEM***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Weight Gain |  | Weight Loss |  | Fever |  |
| Visual Changes |  | Hearing Loss |  |  |  |
| Snoring |  | Coughing Up Blood |  | Short of Breath |  |
| Nausea |  | Reflux |  | Bleeding |  |
| Hematuria (Blood in Urine) |  | Night Time Urination |  |  |  |
| Dizziness |  | Memory Loss |  | Seizures |  |
| Depression |  | Hallucinations |  | Anxiety |  |
| Acute Anemia |  | Low Platelets |  |  |  |
| Female-History of Oral Contraceptives |  | Male-Erectile Dysfunction |  |  |  |
| Goiter |  | Tremors |  |  |  |
| Rash |  | Skin Sores |  |  |  |
| Joint Pain |  | Muscle Aches |  |  |  |

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***PATIENT SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D ATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***